DOSE-REDUCED VENETOCLAX-AZACITIDINE IN ELDERLY ACUTE MYELOID LEUKEMIA: A REAL-WORLD EXPERIENCE

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Introduction

Acute myeloid leukemia (AML) incidence rises steeply with age, and many older adults are unfit for intensive chemotherapy. The VIALE-A trial showed that azacitidine (AZA) plus venetoclax (VEN) improves survival versus AZA alone, but prolonged VEN exposure can lead to extended cytopenias and infections. We explored whether tailoring VEN duration preserves efficacy . Evidence suggests that shorter VEN exposures can maintain efficacy while mitigating prolonged cytopenias and the attendant infectious complications.

Objectives

To assess the feasibility and effectiveness of a VEN–AZA regimen with variable VEN duration in eldery adults deemed unfit for intensive therapy at a Latin American tertiary center.

Methods

Design & Setting

- Single-center retrospective cohort (Nov/2023-Apr/2025), tertiary hospital in Brazil; follow-up to Apr/2025.

Patients

- Ten consecutive AML patients; median age 72 years (64-79); 60% male; de-novo or secondary AML.
- Karyotype: 60% normal.
- Mutations: NPM1 60%, IDH ½ 20%, FLT3-ITD 10%, TP53 10%.
- Comorbidities in 80% (notably hypertension, diabetes, hypothyroidism).

Treatment

- AZA 75 mg/m2 days 1-7 + VEN ramp 100/200/400 mg daily, intended 1-28 per cycle.
- VEN duration individualized: interruptions for intercurrent clinical/surgical events and/or marrow remission. Bone marrow was performed on D21 to assess remission.
- Median VEN exposure: 21 days (range 9–28).
- Pre-treatment cytoreduction for hyperleukocytosis in 4/10 (hydroxyurea ± cytarabine).
- Ten consecutive AML

Assessments & Endpoints

- Primary: morphologic CR.
- Secondary: safety profile, FN rates.
- Descriptive statistics; data cutoff Apr/2025.

Results

Efficacy

- CR achieved in 8/10 (80%) after a median of 1 cycle, irrespective of VEN dose reduction.
- At cutoff, 7/10 (70%) were alive.

VEN Exposure & Modification

- Median VEN days/cycle: 21 (9-28).
- Interruptions commonly after marrow remission or due to clinical events; individualized schedules were feasible.
- 4/10 (40%) required cytoreduction before starting VEN-AZA.

Safety

- FN occurred in all patients (10/10).
- Only one (10 %) developed invasive fungal disease—an individual who had received pre-treatment cytoreduction.

Discussion

Key Points

- Tailoring VEN days (median 21) preserved high remission rates comparable to VIALE-A-era expectations while potentially lowering the burden of prolonged cytopenia/infections.
- Real-world practicality: individualized holds/shortened VEN were implementable without apparent efficacy trade-off.

Limitations

- Small sample (n=10), single center, retrospective design; survival data immature at cutoff. Findings should be validated prospectively.

Conclusion

•In this real-world Latin American cohort, shortened-duration VEN–AZA was feasible and highly effective, reproducing VIALE-A remission rates even in frail elderly patients.

• Curtailing VEN exposure appeared to lessen infectious complications without jeopardizing remission outcomes.

1. Interpretation is limited by sample size and retrospective design. Updated survival data will be reported as follow-up accrues.

References

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